

University of Michigan Hospitals and Health Centers
Patient Safety Competency Quiz
(including answer key & learning sources)

1. **Which of the following is true of health care system errors? (Slides 5, 7 & 8)**
 - a) Errors are often the fault of individuals.
 - b) Thousands of deaths per year are attributed to medical error.
 - c) Errors are usually caused by multiple failures in systems.
 - d) **Both (b) and (c)**

2. **Which of the following act as defense barriers to prevent systems errors? (Slide 9)**
 - a) Improved communication.
 - b) Human factors considerations such as avoiding reliance on memory.
 - c) Standardization of work processes.
 - d) **All of the above.**

3. **Which of the following is true about effective communication? (Slides 15 & 16)**
 - a) Trust is built when there is effective communication.
 - b) Everyone must continuously assess their ability to receive and give feedback.
 - c) Communication skills are acquired (eg. you're not born with them)
 - d) **All of the above.**

4. **Which of the following is not true? (Slide 7)**
 - a) Even "good people" make errors.
 - b) **The impact of errors is minimal for health care professionals, both personally and professionally.**
 - c) Working harder for safe care will not resolve most errors.
 - d) Organizations have a responsibility in creating safer systems.

5. **Which of the following is true regarding patient safety at UMHHC? (Slides 18, 25 & 26)**
 - a) Everyone should speak up and intervene if an error is about to occur, regardless of role or position in the organization.
 - b) Reporting patient care errors, events and safety concerns does not result in disciplinary action.
 - c) All errors provide learning opportunities.
 - d) **All of the above.**

6. **Which of the following is not true when a culture of safety is present? (Slides 12, 22 & 25)**
 - a) Patient safety rounds are conducted to encourage discussion about patient safety.
 - b) Patients are informed of unanticipated outcomes.
 - c) Evidence-based practice guidelines are used in the delivery of patient care.
 - d) **When an error occurs, it is appropriate to blame the person who made the mistake.**

7. **Which of the following is true regarding Incident Reports? (Slides 18 & 19)**
- a) They are used to report all incidents, errors, and near-misses.
 - b) The report is the first step in the analysis and improvement process.
 - c) A report can be filed by any employee.
 - d) **All of the above.**
8. **All of the following are true regarding incident reporting except: (Slides 18, 20 & 21)**
- a) The incident report is legally confidential as a Quality Assurance document.
 - b) The report should be completed immediately after the incident has occurred.
 - c) **Risk Management should not be contacted in the event of patient injury.**
 - d) The purpose of the report is to provide an information base from which corrective and preventive action can be taken to prevent future incidents.
9. **If an error occurs: (Slides 20 & 21)**
- a) Make sure that patient and staff are safe.
 - b) Do not turn off equipment until data is saved (unless further injury would result) and do not dispose of product and packaging.
 - c) Inform your supervisor.
 - d) **All of the above.**
10. **All of the following regarding sentinel events are correct except: (Slides 23 & 24)**
- a) The Chief of Staff is charged with the responsibility for determining if an event meets the criteria for a sentinel event review.
 - b) **The analysis of the event is focused on blaming individuals rather than on systems and processes.**
 - c) Action plans are developed, implemented, and monitored.
 - d) UMHC has a policy on Sentinel Events that describes the review process.

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